

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 103

## CERTIFICATE OF DEATH

06008 66  
Reg. Dist. No.

1. PLACE OF DEATH:  
Garrett  
County.....

City or town..... Swanton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Months

Hospital, Institution, or street address where death occurred:  
Deep Creek Lake - Harveys Peninsula

How long in hospital or institution? ----

3. (a) FULL NAME  
John R. Angle

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

Mae Angle

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) December 28, 1880

8. AGE:	Years	Months	Days	If less than one day
	65	5	6	hrs. min.

Ohio

9. Birthplace..... (Town, county, and state)

10. Usual occupation..... Retired Gas Worker

11. Industry or business..... Natural Gas Co.

FATHER 12. Name..... Henry Angle

MOTHER 13. Birthplace..... Ohio

14. Maiden name..... Unknown Kasler

15. Birthplace..... Unknown

16. Informant..... Mrs. Mae Angle

Address R. D. #1 Swanton, Md.

17. Removal Date thereof June 3, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory to Uniontown, Pa.

Location Buried in plot # 8

18. Funeral director..... Herbert C. Leighton

Address Oakland, Maryland

19. Date rec'd by registrar 19-46 Julian Rowan

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Garrett

City or town..... R. D. #1 Swanton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Miles North Swanton, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1946, at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 June 1946 to 3 June 1946

and that I last saw h. m. alive on 3 June 1946

Immediate cause of death.....

abdominal hemorrhage

sudden

Due to.....

No further information. Patient died

Due to within five minutes after physician

arrived at his home. C. G. O.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

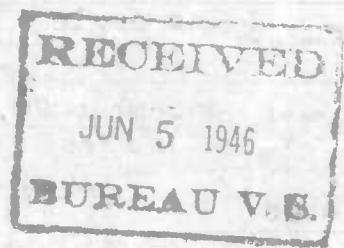
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE G. E. Chase, M.D.

M. D. or other

Address Oakland, Md. Date signed 3 Jun 46



PLEASE WRITE PLAINLY, WRITING IN INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1A

## CERTIFICATE OF DEATH

06009  
Reg. Date No. 6/22/46

## 1. PLACE OF DEATH:

County.....

Garrett.

City or town.....

Bloomington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

17 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Loyal Otto Barnard.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married.

6. (b) Name of husband or wife

Blanche S. Barnard.

7. Birth date of deceased (mo., day, yr.)

May 1, 1915

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

31

01

20

hrs. min.

9. Birthplace

Bloomington-Garrett-Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

W. Va. Pipe &amp; Supply Co.

12. Name

Washington Barnard

13. Birthplace

Garrett County, Md.

14. Maiden name

Julia M. Yoder

15. Birthplace

Garrett Co.

16. Informant

Blanche Barnard.

Address

Bloomington, Md.

17. Cemetery or crematory

Richell Cemetery

Date thereof... June 25, 46  
(month) (day) (year)

18. Location

6 mi W. of Bloomington

19. Funeral director

E. Blanton H. S. Blair

Address

Westernport, Md.

19. b - 25

1946

(Date rec'd by registrar)

Dorsey Patterson

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

2 World War

3. (b) Social Security Number

219-14-5826

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 21

1946 at 12 - m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Blanche Barnard after dark

and that I last saw her alive on

Immediate cause of death

Crushing &amp; destruction of skull

Crushing broken to chest

Due to... Compounded fracture right

rib cage

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident near home Garrett Co. 6/21/46

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) R.R. track

Means of injury Struck by train Injured at work

Locality 846, heel, knee

Signature L. L. Patterson, M.D. Garrett Co.

M. D. or other

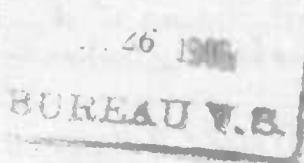
Address Walland, Md.

Date signed 6/22/46

RECEI

JUN 26 1946

BUREAU V.B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(H)*

## CERTIFICATE OF DEATH

Reg. Dist. No. *163**66010*

## 1. PLACE OF DEATH:

County..... Garrett  
 City or town..... Bloomington  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *60 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Henry Jackson Beard

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*6.(b) Name of husband or wife *Edith M. Beard*7. Birth date of deceased (mo., day, yr.) *16 November 1885*8. AGE: Years *60* Months *6* Days *27* If less than one day *hrs. .... min.*9. Birthplace *Bloomington-Garrett-Maryland*  
(Town, county, and state)10. Usual occupation *Miner*11. Industry or business *Coal Mine*MOTHER FATHER 12. Name *James Beard*13. Birthplace *Martinsburg, Maryland*14. Maiden name *Sarah Wolfe*15. Birthplace *Bloomington, Maryland*16. Informant *Paul Beard*Address *Bloomington, Md*17. Burial *Bloomington Cemetery*  
(Burial, cremation, or removal. Which?) Date thereof *17 June 1946*  
(month) (day) (year)Cemetery or crematory *Bloomington Cemetery*  
 Location *Bloomington, Maryland*18. Funeral director *Ellsworth S. Boal*Address *111 Church St, Westernport, Md.*19. *6-12-46* 19. *46* Date rec'd by registrar *Dorothy Patterson*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Garrett*City or town *Bloomington*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

*215-18-8214*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *9 June* 19 *46* af *8:50 p.m.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 9th* to *June 10th*, and that I last saw him alive on *June 9th*.

Immediate cause of death

*Organ Failure*

Due to

Due to

Other conditions

*Pneumonia*  
*Paroxysmal Attacks*

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

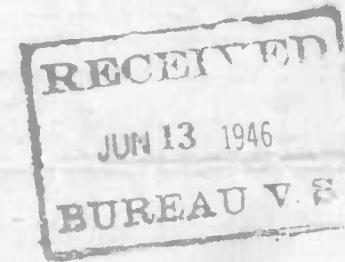
Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE *Dorothy Patterson* M. D. or other *Physician*Address *111 Church St, Westernport, Md.* Date signed *6/12/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

## CERTIFICATE OF DEATH

06011/66  
Reg. Dist. No.

1. PLACE OF DEATH:  
County... Garrett  
City or town... Oakland, Maryland.

(If outside city or town limits, write RURAL and give nearest town)  
Several Years

How long in above place of death?.....  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME  
*Ours*  
Mrs. Virginia B. Lewis.

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced  
Female      White      Widow

6. (b) Name of husband or wife.....  
Deceased      6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)      October 4th, 1879

8. AGE:      Years      Months      Days      If less than one day  
67      8      15      hrs.      min.

9. Birthplace.....  
Petersburg, W. Va.  
(Town, county, and state)

10. Usual occupation.....  
House wife

11. Industry or business

MOTHER FATHER  
12. Name..... William Ours.  
13. Birthplace..... Petersburg, W. Va.

MOTHER FATHER  
14. Maiden name..... Elizabeth Ours.  
15. Birthplace..... Petersburg, W. Va.

16. Informant..... Willie Lewis.

Address.....  
Oakland, Maryland.

17. Burial.....  
(Burial, cremation, or removal. Which?)  
Date thereof..... June 22d/46  
(month) (day) (year)  
Cemetery or crematory.....  
Oakland Cemetery.

Location.....  
Oakland, Maryland.

18. Funeral director.....  
Eunice D. Bolden

Address.....  
Oakland, Md.

19. Date rec'd by registrar.....  
June 22-1946

(Date rec'd by registrar)      19. Date signed.....  
Julia Rowan      6-21-46

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland      County... Garrett  
City or town... Oakland, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number.....  
None

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... June 19th      46      11:30 m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from P. M.  
May 20      1945      to      June 19      1946

and that I last saw h. ex. alive on      June 19th      1946

Immediate cause of death.....  
Carcinoma of Right Ear and neck  
with many Metastases

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....      Date of.....

Where did injury occur? .....  
(City or town)      (County)      (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....      Injured at work?

23. SIGNATURE.....  
M. D. or other

Address.....  
Oakland, Maryland      Date signed.....  
Edmund D. Holmes      6-21-46

RECEIVED

JUN 27 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

66012

Reg. Dist. No.

167

## 1. PLACE OF DEATH:

Garrett

County

Rural Gorman

(If outside city or town limits, write RURAL and give nearest town)

52 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

## 3. (a) FULL NAME

James William Moon

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

Male      White      Married

6. (b) Name of husband or wife Sarah Upole Moon

7. Birth date of deceased (mo., day, yr.) December 11, 1885      6. (c) If alive, give age 59 years

8. AGE:      Years      Months      Days      If less than one day  
61      6      --      hrs.      min.9. Birthplace Mineral Co., W. Va.  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

12. Name Isaac Moon

13. Birthplace Garrett Co., Md.

14. Maiden name Julia Ann Upole

15. Birthplace Garrett Co., Md.

16. Informant Mrs. James Moon

Address Gorman, W. Va. R. D. #1

17. Burial Date thereof June 14, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Fairview Cemetery

Cemetery or crematory 5 mi. West Gorman

18. Funeral director Herbert P. Leyton  
Address Oakland, Md.19. 6/14/46 Ehrn & Shaffer  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland      County Garrett

City or town Rural Gorman

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Mi. West Gorman

(If rural, give LOCATION)

2.(a) If veteran, name war -----

## 3. (b) Social Security Number

235-34-2424

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1946, 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

im 6-8-46 and that I last saw h alive on 19 19

In addition to death Valvular Heart Lesion and Nephritis 1 year DURATION

Hyper tension

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

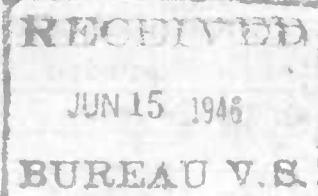
Means of Injury

Injured at work?

23. SIGNATURE

Edison S. G. Anderson  
Oakland, Maryland M. D. or other 6-12-46

Address Date signed



PLEASE WRITE PLAINLY, WITH UNEADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

66013

Reg. Dist. No. 172

## CERTIFICATE OF DEATH

1. PLACE OF DEATH:  
**Garrett**  
County.....  
**Kitzmiller**  
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....**70 yrs.**

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....**Maryland** County.....  
City or town.....**Garrett**  
Street No.....

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

**No**

2.(a) If veteran, name war.....

3. (a) FULL NAME  
**Sarah Elaine Rafter**

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<b>Female</b>	<b>White</b>	<b>Widowed</b>

8. (b) Name of husband or wife.....**Claude Ebenezer Rafter**7. Birth date of deceased (mo., day, yr.).....**Sept. 30, 1872** 6. (c) If alive, give age..... years

8. AGE: Years      Months      Days      If less than one day

**73      8      18**      hrs.      min.9. Birthplace.....**Antioch, Mineral Co., W. Va.** (Town, county, and state)10. Usual occupation.....**Housework** Own Home11. Industry or business.....**William Henry Pool**12. Name.....**Near Martin, Min. Co., W. Va.**13. Birthplace.....**Elizabeth Janney**14. Maiden name.....**Near Keyser, Min. Co., W. Va.**15. Birthplace.....**H.L.Pool**16. Informant.....**Kitzmiller, Md.**

Address.....

17. Burial..... Date thereof.....**June 19, 1946** (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....**Kitzmiller Cemetery**Location.....**Kitzmiller, Md.**18. Funeral director.....**Otha F. Sharpless**Address.....**Blaine, W. Va.**19. Date rec'd by registrar.....**June 18 1946** *Audberwick* Registrar  
(Date rec'd by registrar)3. (b) Social Security Number  
**NONE**

## MEDICAL CERTIFICATION

June 18 1946 at 3A.

20. DATE OF DEATH.....**13 or June 1946**, to **June 18, 1946**  
and that I last saw h. **Dr. J. S. Rafter** alive on **June 18, 1946**.

Immediate cause of death.....

**Broncho-Pneumonia**Due to..... **cerebral hemorrhage****with left-sided paroxysms**Due to..... **Hypertension**

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE.....**Ralph Colandella M.D.** M. D. or otherAddress.....**Hedgesville, Md.** Date signed.....**June 18, 1946**



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

## CERTIFICATE OF DEATH

06614 166  
Reg. Dist. No.

1. PLACE OF DEATH:  
 Garrett  
 County.....  
 Rural Deer Park  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 2 months  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 Deep Creek Lake  
 ---  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 Penna. Washington  
 State..... County.....  
 City or town No. Charleroi,  
 (If outside city or town limits, write RURAL and give nearest town)  
 421 Conrad Ave.  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
 Catherine Ritchey

3. (b) Social Security Number  
 -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife..... Wm. C. Ritchey

7. Birth date of deceased (mo., day, yr.) January 4, 1873

75

6.(c) If alive, give age..... years

8. AGE:	Years	Months	Days	It less than one day
	73	5	3	.....hrs. ..... min.

9. Birthplace..... Bedford Co., Pa.

(Town, county, and state)  
 10. Usual occupation..... House Wife

11. Industry or business..... Own Home

12. Name..... James Jay

13. Birthplace..... Bedford Co., Pa.

MOTHER FATHER  
 14. Maiden name..... Hester Schmidt

15. Birthplace..... Bedford Co., Pa.

16. Informant..... W. J. Ritchey

Address..... R. D. #2 Deer Park, Md.

17. Removal..... June 7, 1946

Date thereof..... (month) (day) (year)  
 to Charleroi, Pa.

Cemetery or crematory.....

Location..... Herbert C. Leighton

18. Funeral director..... Oakland, Maryland.

Address.....

Date rec'd by registrar..... 19. .... 1946

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 7, 1946

19..... at..... 6:00A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

20 May 1946 to 7 June 1946  
 and that I last saw her alive on 4 June 1946.

Immediate cause of death.....

.....

Due to.....

.....

Due to.....

.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

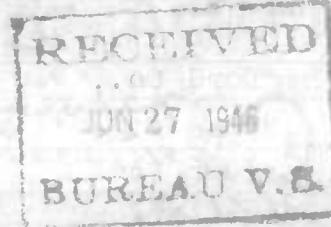
Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... Andrew J. Phane M.D.

M. D. or other.....

Address..... Baldand, Md. Date signed..... 7 June 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

## CERTIFICATE OF DEATH

Reg. Dist. No. 171

1. PLACE OF DEATH:  
County..... Garrett  
City or town..... Shallmar  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3mon.  
Hospital, Institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... W.Va. County..... Monongalia  
City or town..... Morgantown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 52 Kingwood Street  
(If rural, give LOCATION)

3. (a) FULL NAME  
**Betty Jane Sanders**

4. Sex <b>Female</b>	5. Color or race <b>White</b>	6. (a) Single, married, widowed, or divorced <b>Married</b>	
6. (b) Name of husband or wife..... <b>Harold W. Sanders</b>			
7. Birth date of deceased (mo., day, yr.) ..... <b>May 13, 1925</b>			
6. (c) If alive, give age ..... 22 years			
8. AGE: Years <b>21</b>	Months <b>1</b>	Days <b>14</b>	If less than one day ..... hrs. ..... min.

9. Birthplace..... **Mt. Lake Park, Garrett Co., Md.**  
(Town, county, and state)  
10. Usual occupation..... **Stenographer**  
11. Industry or business..... **Dr. office**  
FATHER 12. Name..... **Robert Charles Marvel**  
13. Birthplace..... **Deer Park, Md.**  
MOTHER 14. Maiden name..... **Anna Mary Harvey**  
15. Birthplace..... **Garrett Co., Md.**  
16. Informant..... **Mrs. Anna Marvel,**  
Address..... **52 Kingwood St., Morgantown, W.Va.**

17. Burial  
(Burial, cremation, or removal. Which?) Date thereof..... **June 30, 1946**  
Cemetery or crematory..... **Hamill Cemetery**  
Location..... **Kitzmiller, Md.**

18. Funeral director..... **Otha F. Sharpless**  
Address..... **Blaine, W.Va.**

19. (Date rec'd by registrar) **June 29 1946** *AWR*  
Registrar

3. (b) Social Security Number  
**234-32-7905**

## MEDICAL CERTIFICATION

2D. DATE OF DEATH ..... **June 24** 1946 at **2:30 P.M.**  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Harold** after **death** 19.....  
and that I last saw **him** alive on ..... 19.....

Immediate cause of death ..... **Accidental drowning**  
DURATION .....  
Due to .....  
Due to .....  
Other conditions .....  
(Include pregnancy within 8 months of death)

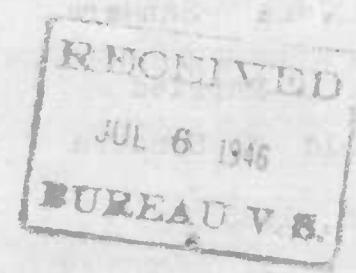
Major findings of operations ..... Date of op. ....

Autopsy results ..... **None**  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. **Accident** Date of .....  
Where did injury occur? **Shallmar** (City or town) **Garrett Co.** (County) **W. Va.** (State)

Injured at home, farm, industry, public place (where?) **Potomac River**  
Means of Injury **Knapping** Injured at work? **No** **Debly bled.**

23. SIGNATURE **J. I. Daingerfield M.D.** M. D. or other **Slanier**  
Address ..... **Oakland** Date signed **6/27/46**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9B2

## CERTIFICATE OF DEATH

6016

Reg. Dist. No. 166

1. PLACE OF DEATH: *Garrison*  
 County .....  
 City or town ..... *Hagerstown Md.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *All his life*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 3. (a) FULL NAME

Sherman Grant Savage

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<i>M</i>	<i>Wh</i>	<i>Married</i>

6. (b) Name of wife..... *Martha G. Savage*7. Birth date of deceased (mo., day, yr.) *Mar - 11 - 1864* 8. (c) If alive, give age *74* years

8. AGE: Years	Months	Days	If less than one day
<i>82</i>	<i>2</i>	<i>17</i>	hrs. .... min.

9. Birthplace..... *711d Garrison Co*  
 (Town, county, and state)10. Usual occupation..... *Farmer*

11. Industry or business

12. Name..... *Cornelius Savage*13. Birthplace..... *711d*14. Maiden name..... *Frieda*15. Birthplace..... *711d*16. Informant..... *Edward Savage*Address..... *Hopwood Pa*17. (Burial, cremation,散骨, or removal. Which?) Date thereof..... *June 23rd - 10 - 46*  
 (month) (day) (year)Cemetery or crematory..... *Calvary Cemetery 711d*Location..... *Hagerstown 711d Henry 711d*18. Funeral director..... *W. H. Savage*Address..... *Frieda'sville 711d*19. (Date rec'd by registrar) *6/9/1946* 19. *Julia A. Rowan*  
 Registrar *actuary*2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... *711d* County..... *Garrison*  
 City or town..... *Hagerstown Md.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)

## 2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *June 8th. 1946* at *6 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 16th. 1946* to *June 8th. 1946* and that I last saw him alive on *May 25th. 1946*.

Immediate cause of death.....

Chronic myocarditis and  
myocardial degeneration

DURATION

Unknown

Due to.....

Due to.....

Other conditions..... None

(Include pregnancy within 3 months of death)

Major findings or operations..... None

Date of op.

None

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

M. D. or other

Address..... *Bruceton Mills, W. Va.* Date signed *6/9/46*

RECEIVED

JUN 27 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

06017  
162

1. PLACE OF DEATH:  
County..... Garrett

City or town..... Grantsville, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... (10) months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Charles R. Sisk Jr.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife..... Mrs. Beth (Collins) Sisk

7. Birth date of deceased (mo., day, yr.)..... Feb. 14, 1915

6. (c) If alive, give age..... 26 years

8. AGE: Years	Months	Days	If less than one day
31	4	14	hrs. min.

9. Birthplace..... Hiawassee, Va.  
(Town, county, and state)

10. Usual occupation..... Minister

## 11. Industry or business

FATHER 12. Name..... Charles R. Sisk Sr.

MOTHER 13. Birthplace..... Pulaski County Va.

14. Maiden name..... Carrie Covey

15. Birthplace..... Pulaski County Va.

16. Informant..... Mrs. Beth Sisk

Address..... Grantsville, Md.

17. Burial..... Date thereof July 2, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Woodlawn Memorial Park

Location..... Bluefield, W. Va.

18. Funeral director..... Alvin Winterberg

Address..... Grantsville Md

19. (Date rec'd by registrar)..... June 29 1946 File #

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Virginia County..... Pulaski

City or town..... Hiawassee  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war..... V

## 3. (b) Social Security Number

233-14-3038

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 28 1946 at 3:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Ghammed after death 19.....

and that I last saw h ..... alive on 19.....

Immediate cause of death..... Accidental drowning

DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of 6/28/46

Where did injury occur?..... Grantsville Garrett MD

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... River Dam

Means of Injury..... Drowning Injured at work? no

Deputy Med. S. J. Baumgartner M.D. Glenmore Hospital

M. D. or other Oak Lane MD Date signed 6/28/46

Address.....

RECEIVED

JUL 2 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

66018

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

162

## 1. PLACE OF DEATH:

County ..... Garrett

City or town ..... Grantsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... from birth

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 3. (a) FULL NAME

William Roy Speicher

4. Sex ..... 5. Color or race ..... 6. (a) Single, married, widowed, or divorced

Male ..... White ..... Single

6. (b) Name of husband or wife ..... None

7. Birth date of deceased (mo., day, yr.) ..... 6. (c) If alive, give age ..... years

February 6, 1938

8. AGE: Years ..... Months ..... Days ..... If less than one day ..... hrs. ..... min.

8 ..... 4 ..... 22 ..... hrs. ..... min.

9. Birthplace ..... Grantsville (Garrett) Md. (Town, county, and state)

10. Usual occupation ..... None

## 11. Industry or business

FATHER 12. Name ..... Robert H. Speicher

13. Birthplace ..... Accident, Md.

MOTHER 14. Maiden name ..... Grace Hershberger

15. Birthplace ..... Grantsville, Md.

16. Informant ..... Daniel Hershberger

Address ..... Grantsville, Md.

17. Burial ..... Date thereof ..... June 30, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ..... Grantsville

Location ..... Grantsville, Md.

18. Funeral director ..... Alvin Winterberg

Address ..... Grantsville C. of C.

19. Date rec'd by registrar ..... June 29, 1946 Ethel Broadwater

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Maryland

County ..... Garrett

City or town ..... Grantsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... June 28, 1946, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

I have no medical history to death 19.....

and that I last saw him alive on 19.....

## Immediate cause of death

Oscillating drowning

DURATION

Doe to .....

Due to .....

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... accident Date of 6/28/46

Where did injury occur? ..... Grantsville Garrett M. (City or town) (County) (State)

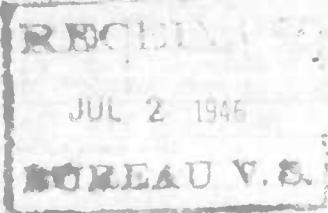
Injured at home, farm, industry, public place (where?) ..... Laurel River Dam

Means of injury ..... Drowning Injured at work? ..... No

Debt, injury, etc. ..... Death, drowning

M. D. or other ..... M. D. or other

Address ..... Oakland Crd Date signed ..... 6/28/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH (6619)

2411 N. Charles St., Baltimore 3rd

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH: Garrett  
 County .....  
 City or town .....Oakland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 yrs.  
 Hospital, institution, or street address where death occurred:  
Seventh Street  
 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Garrett  
 City or town .....Oakland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .....Seventh Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -----

3. (a) FULL NAME  
George Warnick

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>		
6.(b) Name of husband or wife <u>Blanche Murphy Warnick</u>				
6.(c) If alive, give age <u>75</u> years				
7. Birth date of deceased (mo., day, yr.) <u>May 10, 1865</u>				
8. AGE:	Years <u>81</u>	Months <u>1</u>	Days <u>15</u>	If less than one day hrs. .... min.
9. Birthplace <u>Garrett Co., Md.</u> (Town, county, and state)				
10. Usual occupation <u>Merchant</u>				
11. Industry or business <u>Grain and Feed</u>				
FATHER	12. Name <u>Henry Warnick</u>			
13. Birthplace <u>Garrett Co., Md.</u>				
MOTHER	14. Maiden name <u>Mahala Junkins</u>			
15. Birthplace <u>Garrett Co., Md.</u>				
16. Informant <u>Mrs. George Warnick</u>				
Address <u>Oakland, Md.</u>				
17. Burial Date thereof <u>June 27, 1946</u> (Burial, cremation, or removal, Which?) <u>Oakland Cemetery</u> (month) (day) (year) Cemetery or crematory <u>Oakland, Md.</u>				
18. Funeral director <u>Herbert C. Leighton</u> Address <u>Oakland, Md.</u>				
19. (Date rec'd by registrar) <u>6/26/46</u> 1946 <u>Julia Brown</u> Registrar				

3. (b) Social Security Number -----

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1946 at 7:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from See 1946 to June 25 1946 and that I last saw him alive on June 24 1946

Immediate cause of death Chronic myositis  
 Due to Arteriosclerosis

DURATION -----

Other conditions -----  
 (Include pregnancy within 3 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) ----- (County) ----- (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE E. J. Baumgartner M.D. M. D. or other -----  
 Address Oakland, Md. Date signed 6/26/46

CLASSIFIED BY THE STATE DEPARTMENT  
AS UNCLASSIFIED UNDER E.O. 13526

